**Attachment 2 to Appendix 1**
Medicaid Reform - Written Recommendations Received from External Organizations as of October 7, 2005

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| **Nebraska Medical Association (NMA)** | Long Term Care | 1) Nursing Facilities/HCBS Waiver Services – support for community services, which allow the elderly to remain at home or in assisted living arrangements should help keep these costs down. Monitoring these programs for cost effectiveness will be important.<br><br>2) Support for a long-term care insurance program which is simple and affordable could make a significant impact in these costs in the future. Coverage for even two years of care would have a significant impact if a large percentage of people were covered. |
| | Pharmacy | 3) A restricted formulary with generic drugs should be evaluated. Most of the time generic drugs are as effective and safe as branded products.<br><br>4) A low-hassle way to obtain a branded drug when clearly needed should be part of this program.<br><br>5) Many of the costly drugs are for psychiatric problems. A recent FDA advisory suggests that older antipsychotic drugs are safer than some of the new drugs being used. The NMA would assist HHSS in having psychiatrists review these drugs and developing a formulary.<br><br>6) Consider restrictions on other drugs, e.g., antibiotics.<br><br>7) Consider eliminating coverage for over-the-counter medications. |
| | Prevention/ Education | 8) Prevention and education programs to control inpatient hospital utilization.<br><br>9) Support of prevention and health education programs will help shift more responsibility to the consumer. Use Community Health Centers and public health agencies to work with clients on prevention and wellness. |

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| | Chronic Illness Cost Containment | 10) Provide follow-up to encourage clients to take medications as prescribed and to make lifestyle changes, which would improve their health.<br><br>11) Encourage more involvement by the public health system to provide follow-up and education to clients.<br><br>12) Develop incentives for clients to keep their appointments and stay on recommended treatment programs. Develop disincentives for those that do not.<br><br>13) For persons with chronic pain/addiction problems, require that they be seen at regular intervals at an approved pain clinic. Retaining Medicaid coverage should be conditioned on the client's follow-through with these treatment programs. |
| | Personal Responsibility | 14) Consumers need to have a financial stake in their insurance plan and health care expenses, but it needs to be at a level which is affordable.<br><br>15) Incentives for responsible behaviors, and penalties for destructive behaviors, should be part of the Medicaid program. |
| | Prenatal Care Improvement | 16) Active interventions such as home visits and follow-up by a trained health professional are needed. |
| | CHCs/Local Health Department's Role | 17) Community health clinics and regional/county health departments can reach out and help the uninsured before their problems become severe enough to require Medicaid assistance. |
| | Inappropriate ED Use | 18) Inappropriate use of ED services remains a problem. Tools to decrease this problem have been implemented elsewhere and need to be evaluated for use in Nebraska. Another problem is missed appointments. There needs to be a significant penalty in the system to deal with these problems. Access to an extended hours clinic might be helpful in more urban areas where it is feasible. |

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| | Promotion of Health Insurance | 19) Work with the insurance industry to promote affordable health insurance coverage. Need better incentives for employers to offer health insurance to low and middle income employees. |
| | Under-Utilization of Services | 20) Transportation issues need to be addressed. Intervention programs for certain conditions (pregnancy) should be developed. |
| **Nebraska Dental Association** | Sustain Provider Base | 21) Reduce administrative burdens so that provider enrollment and claims processing mirror commercial dental insurance practice. Consider commercial 3rd party provider to administer claims/program.<br><br>22) Prevent erosion of current low reimbursement rates by tying reimbursement rates to a percentage of actual charges submitted.<br><br>23) Assure reasonable scope of basic dental care services for all eligible populations, consistent with contemporary dental practice, treatment, and prevention of dental disease. |
| | Increase Provider Participation to Increase Access to Care | 24) Improve current Nebraska Medicaid rates to a market based system.<br><br>25) Tie reimbursement rates to a percentage of actual charges submitted, similar to Delaware or a 3rd party provider. |
| **Coalition of:**<br>• **AARP**<br>• **ARC of Nebraska**<br>• **Association of Nebraska Community Action Agencies Center for People in Need**<br>• **Children & Family** | Pharmacy | 26) Preferred Drug List (open formulary) (Strategy 1)<br><br>27) Drug purchasing pools (Strategy 2)<br><br>28) Counter detailing or academic detailing (entities other than drug companies, e.g., insurers or purchasers, can provide alternative messages to physicians – Massachusetts targets counter detailing to physicians who prescribe as many as six psychiatric drugs in the same therapeutic class.) The counter detailing could include providing physicians with studies showing, for example, that a much-advertised brand-name drug is no more |

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| **Coalition of Nebraska**<br>• **March of Dimes-Nebraska Chapter**<br>• **National Association of Social Workers-NE**<br>• **Nebraska Advocacy Services, Inc.**<br>• **Nebraska Appleseed Center for Law in the Public Interest**<br>• **Nebraska Association of Behavioral Health Organiza-tions**<br>• **Nebraska Catholic Conference**<br>• **Nebraska Hospital Association**<br>• **Nebraska Statewide Indepen-dent Living Council**<br>• **Visiting Nurse Association of Omaha**<br>• **Voices for Children in Nebraska** | Home and Community Based Services<br><br>Telemonitoring/ Home Med Units<br><br>Smoking Cessation Programs<br><br>Mental Health<br><br>Home Visitation | effective than a less expensive, older alternative. (Strategy 3)<br><br>29) Expand home and community based services (Strategy 4)<br><br>30) Explore use of a health monitoring system that a patient can use to take his or her own vital signs at home and then transmit the information to a central station for clinical evaluation. Such health monitoring systems may reduce inappropriate hospital/ED admissions. (Strategy 5)<br><br>31) Smoking cessation programs for pregnant women and post-partum mothers (Strategy 6)<br><br>32) Reconsider the requirement that Medicaid recipients receiving outpatient mental health services from a Licensed Mental Health Practitioner, who do not have a major mental illness and are not taking medications for their condition, receive an annual Mental Status Exam. Leave the decision to perform an annual MSE to the LMHP and supervising practitioner.<br>Reconsider the requirement that the annual MSE be performed by the LMHP's supervisory practitioner. Allow for the MSE to be performed by any psychiatrist or psychologist chosen by the client, with the results forwarded to the LMHP. (Strategy 7)<br><br>33) Consider covering early childhood home visits to improve the health and well-being of pregnant and parenting women with infants and young children. (Strategy 8) |

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| **Nebraska Parity Coalition** | Mental Health Parity | 34) Reconsider mental health parity as a way to reduce the costs of the State's Medicaid program. Current law allows the use of higher deductibles, copayments and coinsurance provisions for the treatment of mental health than for the treatment of physical illnesses. The unequal formula creates clear disincentives for people to seek early mental health treatment, resulting in greater costs down the road. |
| **Area Agencies on Aging** | Personal Assistance | 35) Reconsider requirement for physician order for personal assistance (PA).<br><br>36) Reconsider the decision to allow HHSS workers outside of Douglas and Sarpy counties to conduct the client self-assessment interviews over the phone.<br><br>37) Reconsider authorizing hours for laundry, cleaning, etc. for PAs living with the client.<br><br>38) Could the state require PAs to pay for their own background checks?<br><br>39) Look into PAs billing while the client is in the hospital, nursing home, or jail. Look into PAs billing while they are in the hospital or jail. Look into PAs billing but not doing the work. |
| | Fraud Issues | 40) Establish a method for hospital/nursing home admitting clerks to notify HHSS when a person on Medicaid is admitted. This information could be forwarded to the HHSS worker and the person responsible for authorizing the billing sheets.<br><br>41) Establish a mechanism for identifying PAs under investigation or convicted of a crime that would prohibit him or her from being under contract with HHSS. |
| | Disability Reviews | 42) Institute more rigorous annual reviews of disability. Some persons who are no longer disabled are still being considered disabled because of self-reporting which may not be accurate. |

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| | Premium Assistance | 43) Consider having Medicaid pay for employer-based health insurance for families when the parents' income is not sufficient to cover the insurance and is within Medicaid income guidelines. |
| | Cost of In-Home Care Versus Facility Care | 44) Examine the cost of in-home care versus the cost of care in a facility. |
| | Income Guidelines | 45) Reexamine income guidelines (1619b). |
| | Senior Care Options | 46) Expand the Senior Care Options program to include a contact by the AAA for everyone seeking nursing facility care. |
| | Medicaid Waiver | 47) Expand the Medicaid Waiver program to encourage home and community-based services as the first option. |
| | Care Management | 48) Expand the Care Management program. |
| **Paula Foster – ENOA Medicaid Case Manager** | Medicaid Buy-In | 49) Allow working and non-working Medicaid recipients to buy into Medicaid. This would require Medicaid recipients to pay the State of Nebraska Medicaid Program directly, rather than purchasing insurance or having a spend down. Also, persons who are not able to work, but have resources above the FPL, should be able to buy into the Medicaid program. |
| **Steve Hess, Midwest Geriatrics (Florence Home)** | Financial Abuse of Older Family Members | 50) Make it more difficult for families to financially abuse their older family members. |
| | Estate Planning to Qualify for Medicaid | 51) Place limits on estate planning to qualify for Medicaid. |
| | Statewide Purchasing Group | 52) Consider a statewide purchasing group for products and supplies |
| **Roger Keetle – AARP, MAHSA, MAHCHA, NHCA, and NHA** | Long-Term Care | 53) Long-Term care savings plan (modeled after the College Savings Plan.<br><br>54) Long-Term Care Insurance Partnership. |

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| | Estate Recovery | 55) Medicaid Estate Recoveries. |
| **Mark Intermill - AARP** | Long-Term Care | 56) New classification of residential long-term care which would provide for some nursing case management, but not on-site 24-hour RN coverage |
| **Nebraska Health Care Association - Pat Snyder** | Long-Term Care | 57) Long-Term Care Savings Account.<br><br>58) Long-Term Care Partnership Program.<br><br>59) Tax Incentives for purchasing LTC insurance.<br><br>60) Mandatory payroll withholding for long term care.<br><br>61) Support expanded authorized pre-tax contributions to 125 savings accounts for long-term care insurance premiums.<br><br>62) Reduce the frequency which service coordinators visit assisted living facilities. |
| | Subsidized Premiums | 63) State Payment/subsidization of Private Health Insurance Premiums. |
| | Estate and Asset Policy | 64) Estate and Asset Policy Reform. |
| | Pharmacy | 65) Preferred Drug List (for non-psychiatric patients). |
| | Purchasing Pools – Drugs | 66) Purchasing Pools. |
| | Pay for Quality | 67) Pay for Quality/Efficiency. |
| | Prevention | 68) Preventative checkups and testing. |
| | Cash and Counseling | 69) “Money Follows the Person”. |
| | Case Management | 70) Improved Case Management. |
| | Incentivize NF or ALF to expand services | 71) Economic Development Incentives. |

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| | Access | 72) Improved access to Medicaid Home & Community Based Services. |
| **Mark Intermill, AARP** | Prescription Drug Cost Containment | 73) Look into Maine Rx Plus and Ohio's Best Rx drug discount program.<br><br>74) Consider older, less expensive, drugs for the treatment of schizophrenia. |
| **Nebraska's Traumatic Brain Injury Advisory Council** | Traumatic Brain Injury | 75) Expand the existing TBI waiver to include community-based service options and not be limited to only assisted living.<br><br>76) Increase the skills, knowledge and awareness of service providers within existing service delivery systems/training is needed to ensure statewide availability of service providers who are knowledgeable about brain injury.<br><br>77) Establish a state-funded Interim Crisis Fund to provide time-limited, flexible assistance in time of need to individuals with disabilities who do not currently qualify for Medicaid or Medicaid waiver services/reduce the number of individuals with disabilities that are forced to go on Medicaid by promoting and funding programs that lead to self-sufficiency through temporary time-limited support. |
| **Vetter Health Services, Inc.** | Long-Term Care | 78) Where population trends do not indicate an opportunity for future growth, the State of Nebraska would purchase and close small, inefficient long-term care facilities.<br><br>79) Create financial incentives for the merger/consolidation of facilities.<br><br>80) Allow owners of a facility to transfer their bed license to other locations where population trends dictate a future need so new facilities could be built.<br><br>81) Allow the sale of licensed beds to providers who would build new facilities in growth areas, or areas in which population trends would indicate a future need for long-term beds.<br><br>82) Work with the Nebraska legislature to pass a law implementing a state tax deduction or credit as |

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| | | an incentive to purchase long-term care insurance. |
| | Long-Term Care Insurance | 83) Provide tax incentives to businesses that offer long-term care insurance as part of their employee benefit package.<br><br>84) Customize a preferred drug list for the state's Medicaid program, including drugs that are most useful in patient care, taking into consideration clinical effectiveness and cost. |
| | Prescription Drug Cost Controls | 85) The state should partner with other organizations and states to form purchasing pools to increase purchasing power and reduce costs. |
| | Estate and Asset Policies | 86) Change the asset look-back period from three years to five years.<br><br>87) Require individuals who transfer their assets into a trust for estate planning to purchase a long-term care insurance policy to cover their long-term care needs for a minimum of five years. If individuals elect not to purchase a long-term care insurance policy, the trust would be responsible for paying for any long-term care.<br><br>88) Make provision for providers to file liens where they are owed monies to prevent assets from being sold before a lawsuit can be filed and a judgment obtained.<br><br>89) Eliminate or reduce the exemption in state law that prevents recovery of the first $5,000 of an estate if children survive the Medicaid beneficiary.<br><br>90) Expand the definition of estate to include assets held in joint tenancy with rights of survivorship, life estates, living trusts, etc.<br><br>91) Require automatic recoveries of small amounts held by Medicaid recipients in long-term care facilities. |
| | Elder Financial Abuse | 92) Pursue cases of suspected elderly financial abuse by families and responsible parties. |

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| | Long-Term Care Savings Accounts | 93) Long-term care savings accounts could be offered as a tax-free savings plan for long-term care, allowing those individuals to deposit a portion of their income each year into their account. Amounts would be withdrawn, tax-free to reimburse long-term care expenses. |
| | Expanded Pre-Tax Contribution Accounts | 94) Allow for long-term care insurance premiums to be deducted pre-tax, and exempt form federal income and Social Security taxes as allowed under the Internal Revenue Code – Section 125. |
| | Eliminate Work Disincentives | 95) Eliminate the disincentive for Medicaid beneficiaries to work full-time or additional hours, making them exceed the income eligibility levels and losing health insurance coverage. |
| | Payments for Services Provided in an Alternative Setting | 96) Payments made by the State for services provided to an individual residing outside of a long-term care facility should not exceed the average payment that the State would have paid if the individual resided in a long-term care facility. |
| | Work Comp Laws | 97) Pass work comp laws that would penalize a person and/or doctor for falsifying an injury for the purpose of extending benefits. |
| | Tort Reform | 98) Pass stricter tort reform laws to prevent excessive settlements that, in turn, would reduce liability insurance premiums. |
| | Create Incentives for People to Enter the Health Care Profession | 99) The State of Nebraska and providers should work together to create incentives and scholarships for students attending LPN and RN programs.<br><br>100) Provide grants for students who wish to become CNAs and CMAs.<br><br>101) To control agency labor usage, there needs to be more professionals in the health care field. |
| **Nebraska Foundation for Medical Care (NFMC)** | Review of Eligibility | 102) Unless there is an internal department review, no one does a review of eligibility in the payment process for accuracy. When NFMC did a Payment Accuracy Methodology (PAM) review, we found a significant number of errors regarding payment |

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| | | issues, including:<br>Out-of-state payments – we have seen several patient with out-of-state addresses who receive benefits from Nebraska Medicaid. We are unsure if they are ever corrected by Nebraska Medicaid.<br>Worker's Compensation – Medicaid has been billed for services provided which were direct results of a work-related injury. This could be screened more effectively if patient records associated with trauma or injury were screened from time to time. |
| | Care Management | 103) Persons with high Medicaid expenditures need someone to coordinate their care. We have reviewed charts where the care is being provided in a fragmented fashion which puts the patient at risk of needing further very expensive care. The Department needs to hire and train a small group of case managers for these patients (and not add them into an already busy caseworkers' caseload). |
| | One Day Stays | 104) The current language in the Regulations regarding inpatient care, outpatient care, and the "24 hour rule" is outdated and causes problems including payment issues because of the rigidity of the rules. A change would allow more consistency and probably save money. |
| | Pre-Authorizations | 105) The Rules and Regulations pertaining to coverage of certain high-cost procedures are somewhat vague and no follow up is done to determine if the procedure performed actually improved the patient's condition. |
| | Multiple vs. Repetitive Single Procedures | 106) There is no consistent review of procedures where multiple procedures are being performed which could have been done at the same time but which are being done separately. The Coding System allows billing for separate procedures done at separate times, when if performed at the same session they would be billed as the initial procedure and multiple subsequent procedures (billed at 50% or less of the initial procedure). This adds to HHSS expense. |
| | Newborn Care | 107) The Diagnosis Related Groups (DRG) system was originally developed for Medicare and |

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| | | subsequently expanded to include other conditions. Newborn Care is an area, which creates significant problems. Anything about a child that is even mildly abnormal can change the DRG, resulting in a dramatic shift in reimbursement. We encourage HHSS to consider requesting a re-evaluation of these DRGs, or the addition of a DRG to more accurately reflect children who may have a minor congenital condition, without jumping to a much higher paying DRG. If unable to change this, HHSS may wish to consider changing it's Rules and Regulations to control billing in this area. |
| | Rehab Transfers | 108) Since hospitals are reimbursed on a DRG basis for inpatient care, it is to their advantage to move a patient as soon as stabilized to a Rehab situation. This becomes more problematic if there is also a rehab unit as a part of the hospital. NFMC has seen cases where a patient was transferred to a rehab unit (generally it is expected that the rehab stay would be several weeks in duration) only to be discharges within a few days. NFMC is concerned that had the patient stayed in the acute care setting a day or two more, the rehab stay would not have been necessary. Since NFMC does pre-authorizations for rehab stays, this can sometimes be caught before the patient goes to the rehab unit. However, with retrospective reviews, where the patient becomes eligible retrospectively, NFMC has no way to control this and are frequently asked to reconsider these areas. |
| **Nebraska Pharmacists Association** | Expand Prior Authorizations | 109) Consider putting all new drugs on prior authorization until the Drug Use Review (DUR) Board can review them. |
| | Appropriate Prescribing/Use | 110) Establish prescriber education program for proper prescribing, therapy and utilization of atypical antipsychotics (mental health medications) and for anti-infectives. |
| | Pharmacist-Based Medication Therapy Management | 111) Implement pharmacist-based medication therapy management services. |

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| | Protect Access to Pharmacists in Rural Areas | 112) Protect access to pharmacists in rural areas. Consider providing incentives to pharmacists to provide medication therapy management services, dispense generics, and continued drug utilization reviews. |
| | Co-Payments and Eligibility Determination | 113) Review the residency requirements for Nebraska Medicaid eligibility. Individuals should be residents of NE for a set amount of time (at least 6 months) before becoming eligible for Medicaid.<br><br>114) Co-payments for prescription drugs should be mandated to curb abuse of the Medicaid system. |
| | Medicare Modernization Act (MMA) | 115) Insist that CMS provide oversight and management of the Medicare/Medicaid eligible (dual-eligible) population to ensure proper therapies and utilization, as well as patient adherence, to control costs. |
| | Provider Services | 116) Improve provider services by creating a more efficient system of submitting claims for durable medical equipment, supplies, and nutritional supplements. |
| **Planned Parenthood of Nebraska & Council Bluffs** | Family Planning Waivers | 117) Investigate Medical family planning eligibility expansions (i.e., family planning waivers). (Twenty-two states currently have obtained family planning waivers.) |